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ABSTRACT

This evaluation report of the Family to Family Program assesses parental attitudes towards their Family to Family experience and the functioning of their emotionally impaired children. It reviews issues of goal achievement; the impact on the targeted problem; service population demographics; and sustainability. Related topics include administration and administrative support; recruitment of consumer families; identification of host families; consumer support services; and characteristics of the consumers and their families. The report assesses all four variables proposed in the evaluation plan including: the functioning of participating children, family cohesion and adaptability, and parental attitudes about personal and family issues using the Family to Family Questionnaire. The evaluation concluded that the program succeeded in achieving its stated goals of providing appropriate families with respite services. Child, family, and parent variables measured by the three instruments all yielded significant evidence for the efficacy of the program. All statistical indices suggest that children, families, and parents function better as a result of the program's services. (JDM)

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FINAL EVALUATION REPORT

FAMILY TO FAMILY PROGRAM

May 2000

Luellen Ramey, Ph.D and David P. Meyer, Ph.D.

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Family to Family Program

Third Year Evaluation Report
May 2000

Introduction and Scope of Report

This evaluation report covers the period from March,1999 through April, 15, 2000. It will cover issues of goal achievement, impact on the targeted problem, service population demographics and sustainability (Skillman Foundation,1996) . Related topics include administration and administrative support, recruitment of consumer families, identification of host families, consumer support services and characteristics of the consumers and their families. The children served by the program will be described based on clinicians' ratings on the Child and Adolescent Functional Assessment Scale (CAFAS) (Hodges, 1990). Parental attitudes toward the program will be described using the Preplacement Questionnaire and family dynamics by the Family Cohesion and Adaptability Scale II (FACES II) (Olson, et al. 1986). This report will therefore assess all four of the variables proposed in the Evaluation Plan. These variables and the means of assessment are:

1) Functioning of participating children. (CAFAS)
2) Family cohesion. (FACES II)
3) Family adaptability. (FACES II)
4) Parental attitudes about personal and family issues which the program is designed to ameliorate. (Family to Family Questionnaire)

As noted in previous reports, these data were gathered on all enrolled families and children at the time of enrollment. The Evaluation Plan calls for the same instruments to be administered post treatment as well. A minimum treatment of six months has been agreed upon for all children in the program for evaluation purposes. Pre and post data were to have been collected when cases of at least six months program duration were closed and for all cases of six months duration or more at the end of the third year of program operation. Unfortunately, there have been difficulties in gathering the post data due to a number of causes, including family relocation and remissness of clinicians in supplying CAFAS data. Moreover there was uncertainty on the part of the program staff as to whether a third and final Evaluation Report was required. The

evaluators were told in February that no report was required; later that one would indeed be needed, and the May deadline was negotiated.

Accomplishment of Program Objectives

The overall goal of the Family To Family demonstration project was to keep families of emotionally disturbed children intact by supplying volunteer respite providers (who are paid a small stipend) within the community. The proposal considered that the program might alleviate several aspects of the problems faced by the families of special needs children who are emotionally disturbed. These can be considered mediate program objectives:

1) Need for respite. Parents of these children experience serious, even overwhelming stress in carrying out the relentless demands of parenting. Respite care has been shown to provide an important and restorative break in these demands, and provide the entire family with benefits to their well being.

2) Family isolation. Extended family and friends may avoid a family with emotionally disturbed children, leaving them isolated. The intent of the program is to provide these families with opportunities to interact with family and friends during respite periods and in some cases to involve extended family or friends in providing respite.

3) Crises. Theses families are at serious risk for crisis situations which they may be ill equipped to manage. Respite care can reduce the incidence and severity of crises by reducing the feelings of anxiety, being overwhelmed. and chaos which are endemic in families with emotionally disturbed children.

4) Lack of parental role models. The program seeks to provide children with additional parental role models through respite care and to improve parenting skills in the family of origin through various supportive services (Family to Family Proposal, 1996).

Specifically, the Family to Family Program has sought to provide respite care for 25 families with emotionally impaired children through regular out of home care with host families. As noted, this is intended to keep consumer families intact. and to improve family functioning and quality of life. In order to accomplish these ends, the Family to Family program engaged in three major activities:

1) Identifying and enrolling appropriate consumer families;
2) Recruiting suitable host families and arranging the respite care;
3) Providing ongoing support to both consumer and host families.

This report will evaluate the program in terms of those activities over the past year, as well as the level of administrative support on the part of the Oakland County Community Mental Health Authority. In addition, we will examine the impact on the consumers and their families through analysis of pre and post data gathered by the Family To Family staff. The evaluative process therefore attempts to respond on the macro level of meeting a community need, on the mezzo level of improving the quality of life of particular family constellations, and at the micro level of targeting changes in the behavior of individual emotionally disturbed children.

Identifying and Enrolling Appropriate Families

The Family To Family Program has depended upon OCCMHA clinicians to identify from their caseloads appropriate children and families for referral to the program. After some difficulty with start up, and a period of underenrollment relative to program capacity, the program currently has 23 children from 21 families (April. 15, 2000). Because a number of enrolled families have moved from the area, or terminated their participation for other reasons, recruitment has been an ongoing activity for the staff, requiring constant effort and communication with the clinicians to obtain referrals. That these efforts have paid off is evident from the near full enrollment, and occasionally a waiting list. . Reasons for termination are: moved from area / unable to contact (11), unsuitable for the program (5), placement in foster care or restrictive environment (3), and surrender of parental rights (1). The program staff report a good level of cooperation from clinicians and an increasing collaboration from those in the previously underrepresented northern area. Overall, the recruitment of suitable consumers is evaluated as satisfactory.

Recruiting Suitable Host Families

The recruitment of suitable host families for the emotionally disturbed children enrolled in the Family To Family Program has presented some problems, due to the nature of the special needs children. However with considerable ingenuity and utilizing the extended families and friends of the children's families of origin, every case has resulted in at least some respite care, and in nearly all cases a mutually satisfactory arrangement of respite has been worked out. The stipend for host families which was $45 per day has been increased to $65, a needed improvement. The maximum number of respite days is 108 per year (9 days per month), so that some creativity is required to reach a satisfactory accommodation. Considering the difficult children who have a high incidence of hyperactive, impulsive and aggressive disorders enrolled in this program, we evaluate this aspect of the program to be satisfactory.

Providing Ongoing Support

It is apparent to the evaluators from their contacts with program staff that the Oakland County Community Mental Health Authority has provided appropriate training, supervisory and physical support for the program. The original Family to Family Program Coordinator, Christine Miller, left the position and has been replaced by Terry Clisshold who has carried out the job in a diligent and professional manner. Her supervisor, Michelle Quarton, who oriented and trained Ms. Clisshold, has also been replaced by Kris Mazzei. The Program Coordinator is responsible for the day to day operation of the program, carrying out numerous activities to encourage clinicians to refer appropriate consumers to the program, to locate and negotiate with host families, to assist enrolled families with various problems, to provide informational and educational support for consumer and host families, and to carry out administrative and recording activities. The Program Coordinator, Ms. Clisshold, has provided these

services to enrolled families in a timely and supportive manner. She has produced a quarterly newsletter for the program participants and conducted various meetings and training sessions for families as needed. We consider her commitment, professionalism and interpersonal skills to be indispensible elements in the success of the program this past year. As for the other aspects of providing for the Family to Family program: technical, secretarial, space, supplies and other material resources; all seem adequate to the needs of the enterprise. Consequently, the provision of support to various constituents is judged to be satisfactory.

Consumer Demographics

Consumers have ranged in age from 5 to 17 with a mean for those currently enrolled of 12 yr., 8 mos. The 13 consumers enrolled during the past year ranged from 9yrs. 0 mos. to 17yrs. 0 mos. with a mean age of 12 yrs. 10 mos. Of these 9 were males and 4 were females. The current enrollment is divided into 18 males and 5 females. Two families, it should be noted, have two children in the program.

CAFAS Measurements

The CAFAS yields 4 scores (0 = no/minimal impairment; 10 = mild impairment; 20 = moderate impairment and 30 = severe impairment) on five scales listed below.

1. Role performance - subscales are school/work, home and community.
2. Behavior toward others.
3. Moods/self harm - subscales are moods/emotions and self harmful behavior
4. Substance abuse
5. Thinking

Where there are subscales, the highest of the scores is used. The 5 Scales are summed to yield a Total Youth Score ranging from 0 to 150. Clinical indicators for Total Youth Scores are:

10 = may benefit from some intervention or prevention.

20-30 = treatment on an outpatient basis assuming no risk factors (suicide, self or other harmful due to aggression, sexual behavior or firesetting, or psychotic/organic symptoms with severe incapacitation.

40-60 = may need services beyond weekly outpatient visits, but not likely residential treatment.

70-80 = may need intensive therapeutic program, depending on resources and risk factors.

90 or higher = restrictive/supervised living situation may be needed.

The Family to Family Program appears most suitable for children of moderate CAFAS Total Youth Scores, though those with more severe dysfunction might also benefit with additional supportive services. In fact we do find a wide range of Total Youth Scores: from 30 to 110 at entry. The mean entry Total Youth Score of current consumers in the program was 64.3, indicating a midrange level of impairment and a need for

services beyond weekly outpatient care. This is comparable to the scores reported in previous reports: 66.5 last year, and 64.5 two years ago. Of the 23 currently enrolled program consumers, 4 had entry CAFAS Totals of 90 or more, indicating a need for careful monitoring and high level supportive services. Case notes indicate that all these cases are working out with the host families. Mean entry CAFAS scores of current consumers on the five scales along with numbers of consumers falling into the three impairment levels are summarized in Table 1.

Scales	Mean Scores	Impairment Levels # Severe	# Moderate	# Minimal
Role Performance	22.7	10	9	4
Behavior toward Others	13.0	1	9	13
Moods/ Self Harm	18.6 (Moods = 14.3)	3	10	10
Substance Abuse	0	0	0	0
Thinking	4.78	1	3	19

Table 1. CAFAS Scores, Current Enrollees (n = 23)

Of the 23 current cases, 7 had scores of 70 or higher, 12 had scores of 40 to 60, and 4 had scores of 30 or less. As table 1 indicates, Role Performance was the most common severe impairment and had the highest mean score; Moods was next in mean score and had the largest number of moderate impairments; Behavior toward others was also a common problem. Self Harm, and Thinking were less common and less severe, while Substance Abuse was not a problem in this group.

Risk Factors were evaluated in 7 of the cases; of these, 5 were for aggression, and 2 for other factors. The number of aggressive risks is supported by DSM IV diagnosis of oppositional defiant disorder in 6 cases and attention-deficit/ hyperactivity disorder in 13 cases (some with ODD). A diagnosis of dysthymia occurred in 3 cases. No other DSM IV diagnosis appeared more than once.

The two optional scales, Caregiver Resources: Material Needs, and Family/ Social Support were rated in 20 cases. Table 2 summarizes these ratings of the primary caregivers.

Impairment levels	Caregiver Support: Material	Family/Social
0 - None	9	1
10 - Mild	9	9
20 - Moderate	2	9
30 - Severe	0	1
Mean Caregiver Support Level:	7.5	15

Table 2: CAFAS Caregiver Support Ratings (n=20)

It is clear from Table 2, that this group of families does better at providing for their children's physical needs than their social and emotional needs, and providing a home setting free from such risks as abuse or parental alcoholism. It is noteworthy that just one family was rated as having severe impairment in either category. The mean rating indicates problems in the social support area from mild to moderate, so that staff monitoring of the consumer family situation was in order. These support ratings are similar to last year's, when means for material and social support were 7.2 and 14.4.

Statistical Analysis of CAFAS Scores

CAFAS scores were gathered prior to entry into the Family to Family Program and at exit, providing the six months requirement was met,or at the end of the three year cycle, set at April, 15, 2000. These pre and post scores were then analyzed, employing the t- test for nonindependent samples. This technique is also referred to as the correlated, or dependent t-test The measure which is analyzed by this test is the mean difference between the paired scores. Table 3 shows the relevant details of the analysis.

Variables	N	Mean	St. Dev.	df	t	Sig. (1 tailed)
Pre CAFAS	25	64.4	25.51			
Post CAFAS	25	48.4	22.85	24	3.024	.003

Table 3: CAFAS Statistical Summary

Table 3 reveals a t-test value of over 3, in this case, significant at <.003 Thus we would predict this strength of relationship to occur by chance in fewer than three in ten thousand cases. This far exceeds the .01 level of confidence usually specified in social research. The one tailed test was called for because there was reason to believe that CAFAS scores would decline (i.e. improve) with the application of respite and other services offered through the OCCMHA. A finding of this magnitude supports the clinical hypothesis that the Family to Family Program contributes to the well being of the the children whose families are in the program.

Measures of Family Cohesion and Adaptability: the FACES II

The Family Adaptability and Cohesion Scales have been developed over the past two decades by D. H. Olson and colleagues of the Family Inventories Project at the University of Minnesota. These instruments are based on the Circumplex Model of family functioning (Olson, 1983); and were described in last year's report. However to spare the reader a search for that document, we offer this brief explanation of the FACES II instrument and its underlying rationale. The FACES II instrument measures two dimensions of family functioning:

- cohesion: the degree to which members are connected to/ separated from the family.
- adaptability: the extent to which the family is able to change and be flexible.

FACES II linear scoring results in 4 levels of cohesion (disengaged, separated, connected and very connected), and 4 levels of adaptability (rigid, structured, flexible and balanced). There are 16 possible combinations of these 4 levels with each other yielding 4 family types. Figure 1 illustrates these types and the threefold clinical labels associated with them-- balanced, midrange and extreme.

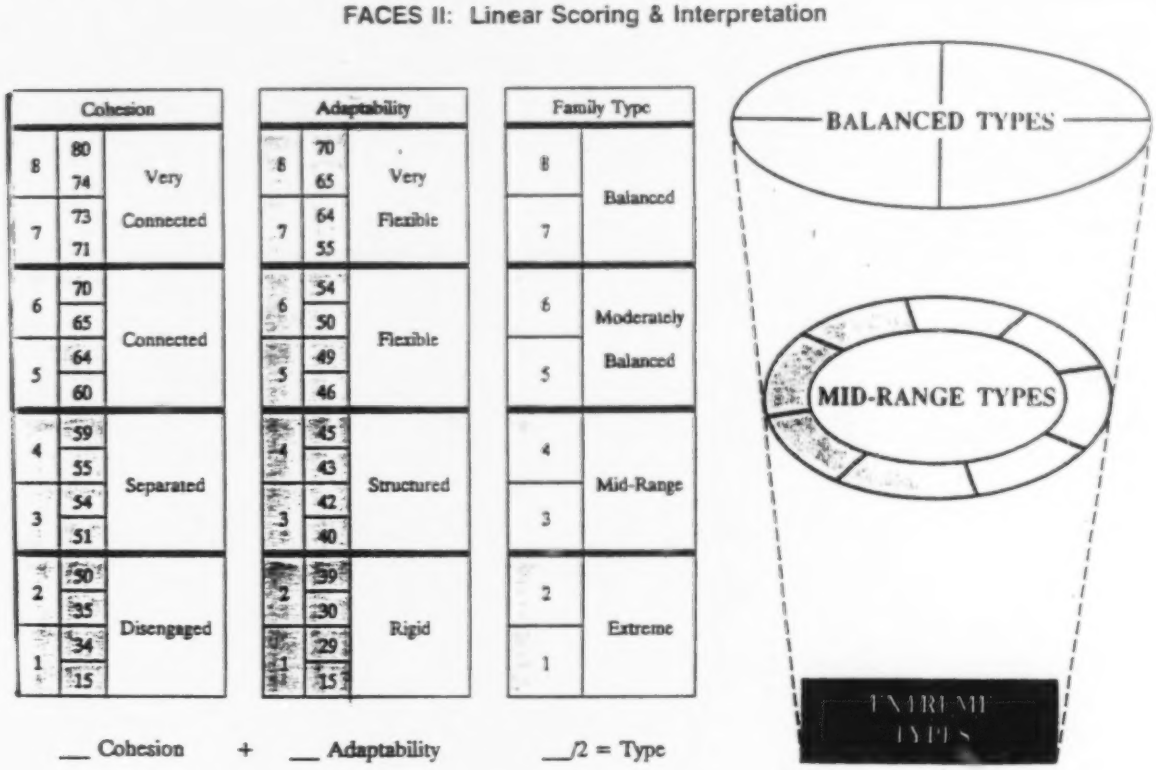

FIGURE 1. FACES II: Linear Scoring & Interpretation

As noted in last year's report, the FACES II instrument has good reliability (Cronbach alpha's of .87 for the Cohesion scale, .78 for the Adaptability scale, and .90 for the total scale). Validity of the instrument is supported by concurrent studies and a well articulated and persuasive underlying theory--the Circumplex model of family functioning (Olson et al., 1983, 1991).

For the purposes of this study comparisons were made between pre and post Cohesion scores, pre and post Adaptability scores and pre and post Family Type scores (1 through 8). Pre and post FACES II measures were available for 26 families of six months or longer duration or longer in the program. As before the statistical method used to analyze these data was the the t-test for nonindependent samples. A directional (one tailed) test of significance stems from the initial hypothesis that respite care would

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result in improved family functioning (OCCMHS Family to Family Proposal, 1996). Table 4 shows the results of the statistical analysis performed on pre versus post FACES II scores. Higher scores on all these variables indicate better functioning.

Variables	N	Mean	St. Dev.	df	t	Sig. (1 tailed)
Pre Cohesion	26	50.54	12.60			
Post Cohesion	26	56.62	8.66	25	-5.043	.00003
Pre Adaptability	26	40.31	7.48			
Post Adaptability	26	42.73	6.01	25	-.4.239	.00003
Pre Type	26	3.40	1.57			
Post Type	26	3.92	1.55	25	-3.863	.0005

Table 4: FACES II Statistical Summary

The results from the analysis above clearly show improvement in all three aspects of family functioning as measured by the FACES II test. Both Cohesion and Adaptability scores were literally off the scale in terms of significance. The authors had to consult a number of charts before estimating the significance levels due to these extreme t-test values The SPSS program used to run these data only supplies such levels to three decimal places (two tailed). This is a problem most researchers would be delighted to face. The odds against such a difference occurring by chance are three out of a million for Cohesion and Adaptability scores and five in one hundred thousand for the Family Type scores. These extremely significant values strongly support the hypothesis that the combination of services, including respite care through the Family to Family program, improves family functioning. As we shall note in the discussion later, we cannot isolate with certainty the exact role that the program played in bringing about these results. due to the nature of the research design. Nevertheless the change did clearly occur in the hypothesized direction.

Family to Family Questionnaire

This questionnaire was developed from an earlier longer instrument developed by the evaluators for the Association of Retarded Citizens of Oakland County program of respite services (Ramey and Meyer, 1990). It consists of 10 questions relating to the goals of the Family to Family program; the items are arranged in a 4 point Likert type scale with 1 being a desireable lack of problems/high functioning,and 4 representing the presence of problems/low functioning. Parent(s) are asked to rate the following areas:

- ability to maintain the child(ren) at home (Q1)
- stress level for self (Q2), and family (Q3)
- time available for self (Q4), other children (Q5), spouse (Q6), and friends (Q7)
- ease of childcare arrangements (Q8)
- sense of control over one's life (Q9)
- adequacy of outside support (Q10)

The Family to Family Questionnaire is easy to administer, score and interpret and derives construct validity from its direct connection to the goals of the program. Pre and post Family to Family Questionaires were availaible for 27 parents of children in the program and the overall results were submitted to statistical analysis using the t-test for nonindependent samples. Table 5 shows the results of this analysis.

Variables	N	Mean	St. Dev.	df	t	Sig.(1 tailed)
Pre Questionaire	27	3.10	.593			
Post Questionaire	27	2.19	.530	26	8.044	.000001

Table 5: Family to Family Questionnaire Statistical Summary

The t value of over 8 is significant at a better than one in ten million level of confidence. Little more can be said-- this is not a chance relationship. It is clear that parents improved significantly overall in measures covered by this instrument. The largest gain scores were for Q7, time available for friends (-1.44); Q8, ease of childcare arrangements (-1.37); Q10, adequacy of outside support (-1.27); and Q4, time available for self (-1.23). All question scores improved, with a mean improvement score of 0.91. This is a phenomenal improvement on a 4 point scale, as the t-test results reveals. Table 6 shows the means and gain scores fo each of the to Family to Family Questionnaire items.

Question	1	2	3	4	5	6	7	8	9	10
Pre Mean	2.35	2.91	2.91	3.56	3.12	3.21	3.88	3.37	2.83	3.15
Post Mean	1.74	2.15	1.96	2.33	2.33	2.58	2.44	2.00	1.89	1.88
Gain Score	0.61	0.76	0.95	1.23	0.79	0.63	1.44	1.37	0.94	1.27

Table 6: Family to Family Questionnaire Item Analysis

Inspection of Table 6 reveals that Q1, ability to maintain child at home and Q6, time for spouse, had the lowest gain scores, quite a bit lower than all others. We may speculate that respondents were either loathe to admit problems in these two crucial family areas of responsibility or that they placed more emphasis on these two aspects of family life. But even these items improved by a relatively large amount, given the 4 point scale. This table shows the magnitude and pervasiveness of gains in important measures of family well being. Moreover it should be noted that items with pre means of 3 or more, indicating more severe problems, tended toward the largest gain scores-- most over 1 point.. These problem areas, in order of severity were: Q7, time for friends; Q4, time for self; Q8, ease of childcare arrangements; Q6, time available for spouse; Q10, adequacy of outside support; and Q 5, time available for other children. In sum, we consider the difference in pre and post Family to Family Questionnaire scores to be strong evidence for the success of the program in meeting

consumers' needs and enhancing the quality of their lives. The fact that the instrument was designed specifically to tap into the program's objectives is a strength, but as a result is nonstandardized, of unknown reliability and only construct validity.

Methodological Issues

As in all program evaluation ventures, compromises and tradeoffs inevitably detract from the ideal design. This undertaking was no exception. Ideally we would have chosen a true experimental design-- a post-test only control group design, for example. However, reality intervened and we were unable for obvious administrative and ethical considerations to realistically plan such an experimental approach. No large pool of prospective consumers existed: clients were referred by clinicians from their caseloads, and it was difficult to ramp the program up to speed; only a limited number of cases were deemed suitable for the program. Even if more potential consumers had been available, the ethical dilemma of denying service to suitable families was insurmountable. Therefore we proposed a quasi experimental evaluation employing pre and post measures on a single group of consumer families. Even so, it was not easy to track down families and obtain the post data. It was due to the tenacity of the Family to Family Coordinator, Terry Clisshold, that an adequate number was obtained, permitting statistical analysis. However, the quasi experimental design has weaknesses. These weaknesses include rival hypotheses accounting for changes that would in a stronger design be confidently assigned to research hypotheses. The plausible rival hypotheses include history, maturation,testing effects, and statistical regression (Isaac and Michael, 1977). Let us consider each of these briefly with respect to this program.

- History: Something may have occurred during the interval between pre and post testing which might influence the outcome. In this case children in the program did continue to receive clinician services and possibly other non program attention (e.g. medication).

-Maturation: This is especially important with young children. As they develop, rather considerable behavioral and psycho/physiological changes occur, which may in some measure account for the observed changes.

-Testing effects: the mere act of pretesting can create differences in the posttesting, or sensitize program participants to certain issues which modify their posttest performance.

-Statistical regression: This occurs when an extreme group is used in the study, which very well may have been the case with Family to Family participants. The extreme scores, when repeated, will regress toward the mean, accounting for some of the change.

It is likely, that some or all of these factors were at work in this evaluation study. They should be born in mind when interpreting what otherwise seems to be a very convincing statistical case for the efficacy of the Family to Family program.

Conclusions and Discussion

This evaluation concludes that the Family to Family program has succeeded in achieving its stated goals of providing appropriate families with respite services in order to enable the families to maintain the child(ren) at home, to enhance family quality of life, to reduce family crises and to provide parental role models for the children. The program staff and clinicians have collaborated to maintain enrollments at or near the intended capacity of 25. The Program Coordinator has also managed to assist families to locate suitable host families to provide respite care in all cases without undue delay. We also found considerable evidence of appropriate case intervention where necessary, and ongoing contact by the Program Coordinator with the enrolled families.

The transition from Skillman Foundation supported demonstration project to regular OCCMHA program has gone smoothly with existing personnel remaining on staff. Funding for the program has shifted to the general ledger of OCCMHA .

Child, family and parent variables were measured by means of three instruments: the CAFAS, the FACES II and the Family to Family Questionnaire, all administered pre and post at least six months treatment. Ratings of children by clinicians on the CAFAS improved; t-test analysis revealed a .003 level of significance. FACES II results were also significant at the .00003 level for cohesion and adaptability, and at the .0005 level for type. The analysis of the Family to Family Questionnaire data also yielded an astronomical significance level: .000001. While this is powerful evidence for the efficacy of the program, we urge cautious interpretation due to the quasi experimental , pre- post test design .

Overall, we must conclude that the Family to Family program has been a resounding success. All clinical and administrative oversight indicates attainment of all program goals and objectives, a competent and committed staff, appropriate clients, suitable services and smooth integration into OCCMHA's regular program offerings. Beyond that, all statistical indices suggest that children, families and parents function better as a result of the program's services.

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